STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

HOME HEALTH Services:

7(c) **Medical Supplies, Equipment and Appliances:**

Provided by or through the auspices of a home health agency:

Prior authorization is required for unusual and excessive amounts of medical supplies (more than one month's supplies) when the costs exceed certain limits. Durable medical equipment (DME) that is either rented or owned by the HHA cannot be billed to the NJ Medicaid Program.

DME, large amounts of medical supplies, and prosthetics and orthotics that are provided under the auspices of a home health agency require prior authorization, and are payable to the vendor/provider of the specific service, not the home health agency.

Provided by a vendor:

Prior authorization is required for selected durable medical equipment or medical supplies if the provider's charge exceeds limits established by the Division. Selected items require prior authorization regardless of the charge.

All initial prescriptions, including those for protein nutritional supplements and specialized infant formula, shall be limited to a 34-day supply and all refills shall be limited to a 34-day supply or 100 unit doses, whichever is greater.

The least expensive, therapeutically effective protein nutritional supplements or specialized infant formulas shall be dispensed if the prescriber has not indicated "brand medically necessary" on the prescription.

Selected DME is limited to used DME when available.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
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Home Health Services:

7 (d)

Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Provided by a Home Health Agency:

Same limits as in 7(a), when the services are provided by an home health agency.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

8 **Private Duty Nursing Services:**

Private duty nursing services are not provided, except for EPSDT recipients.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

9. **Clinic Services:**

Services requiring prior authorization, second opinion, or certification of medical necessity, when performed in other approved settings, similarly require prior authorization when performed in an independent clinic. This limitation pertains to dental services, physician services, podiatrist services, rehabilitation services, ambulatory surgical center services, and optical appliances.

Only one mental health service can be provided per patient per day, except that medication management can be provided on the same day as other mental health services, exclusive of partial care.

Prior authorization is required when mental health services exceed $6,000 in payments to an independent clinic for any one Medicaid recipient in a 12-month service period.

Physical therapy, occupational therapy, and therapy for speech/language pathology require prior authorization after the initial visit. Only one treatment session of physical therapy, occupational therapy or speech/language therapy can be provided per recipient per day.

A Medical Day Care Center evaluated as providing substandard services and/or inadequate documentation of services may be subject to a plan of correction addressing deficiencies noted by Division staff. If a follow-up on-site visit reveals that the plan of correction was not being implemented, prior authorization of services may be implemented. Alternative measures include a ban on new admissions to the center or termination of the provider agreement. Prior authorization may be used, upon the discretion of the Division, with new medical day care providers. This limitation applies to all Medical Day Care Centers, whether they are hospital affiliated, nursing facility based, or free standing.

Administration of approved injectable or inhalation drugs by a physician requires no prior authorization. Other unapproved injectables are not covered as a physician service, but are covered as a pharmaceutical service. This policy does not apply to immunization.

HealthStart services are limited to pregnant women and dependent children under the age of two.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

9. **Clinic Services:**

Immunizations are limited according to Division guidelines as follows:

(1) Routine childhood immunizations provided in accordance with Division guidelines;
(2) *Post -exposure prophylaxis; or
(3) *Selected high-risk groups.

*Regardless of age

Medical services, medical procedures or prescription drugs whose use is to promote or enhance fertility are not a covered service.

Expanded adolescent family planning services, including provisions for risk behavior assessment; contraception education and counseling; health education and counseling; and care management activities are limited to individuals under 21 years of age.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

10 **Dental Services:**

Prior authorization is required for removable prosthodontic replacements and periodontal treatment. Prior authorization is required for selected dental services and selected orthodontic work.

Dental examinations, prophylaxis, and fluoride applications are limited to once every 6 months for patients through age 17, and once every 12 months for patients 18 and older, unless prior authorization is obtained for more frequent treatment.

Reimbursement for selected oral X-rays is limited by both frequency and age factors.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

11(a) **Physical Therapy: (PT)**

Provided. No requirement for prior authorization for such services when provided as Medicare benefits.

Medicaid eligible recipients may receive PT rendered by a home health agency or nursing facility (NF). This service is subject to a post payment clinical audit by DMAHS professional staff.

Prior authorization is required, after an initial visit, for PT provided by a physician (within the scope of practice) or an independent clinic.

PT provided as part of an inpatient hospital stay or as an outpatient service does not require prior authorization.

Only one PT treatment session may be provided in the same day, if the services are not provided as part of an inpatient hospital stay.

There is no direct Medicaid reimbursement for privately practicing therapists.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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11(b) **Occupational Therapy: (OT)**

Provided. No requirement for prior authorization for such services when provided as Medicare benefits.

When OT is provided to recipients by a home health agency or in a nursing facility (NF), the service is subject to post payment clinical audit by DMAHS professional staff.

Prior authorization is required, after the initial visit, for OT services provided by an independent clinic.

Physician offices are not reimbursed for OT.

Prior authorization is not required for OT services provided as part of an inpatient hospital stay or as part of an outpatient hospital service.

Limited to only one OT treatment session per day when not provided as part of an inpatient hospital stay.

There is no direct Medicaid reimbursement for privately practicing therapists.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

11(c) **Services for Individuals with Speech, Hearing and Language Disorders:**

No requirement of prior authorization for such services when provided as Medicare benefits.

For individuals requiring services for speech and language disorders, such services are limited to services when provided in the following sites:

Patient's own home
Nursing facility
Independent clinic
Physician's office
Outpatient hospital department, or
As part of an inpatient hospital stay.

When speech-language therapy is provided by an approved home health agency or in a nursing facility, the service(s) are subject to a post-payment clinical audit by DMAHS professional staff.

In cases where the services are provided in the patient's home by other than an approved home health agency, or in a physician's office or by an independent clinic, after the initial evaluation, prior authorization is required.

Services provided during an inpatient hospital stay, or as part of the outpatient hospital department, do not require prior authorization.

Therapy is limited to one treatment session per day when not provided as part of an inpatient hospital stay.

There is no direct Medicaid reimbursement for privately practicing therapists.

For individuals requiring services for hearing disorders, practitioner services are limited to services provided by a physician, independent clinic or as part of a hospital outpatient service. No payments are made to privately practicing audiologists.

Hearing aids are provided if determined medically necessary utilizing criteria established by the Division. Pre-payment approval is required after a hearing aid is dispensed to a Medicaid recipient residing in a nursing facility (NF). Replacement hearing aids are provided if necessary, utilizing criteria established by the Division.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Limitations on Amount, Duration and Scope of Services
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11(c) Cont'd

Services for Individuals with Speech, Hearing and Language Disorders:

An otologic examination shall be performed prior to prescribing a hearing aid. The physician performing a medical examination of the Medicaid eligible beneficiary shall determine if an audiological examination is medically necessary for beneficiaries 21 years of age or older. All Medicaid eligible beneficiaries under 21 years of age shall have an audiological examination completed prior to the prescribing of a hearing aid.

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